# Medical Release Form

**To Be Completed by a Physician**

| | |
|---|---|
| Physician: _____ | Date: _____ / _____ / _____ |
| Fax No.: _____ | Phone: _____ |
| Patient's Name: _____ | Birth Date: _____ |

Your patient has requested to participate/return to participation in the following program(s):

☐ Supervised Exercise ☐ Unsupervised Exercise

Due to their medical history it is necessary that we request a medical clearance.

Contraindications for participation are as follows:

- ❑ Unstable orthopedic condition
- ❑ Uncontrolled diabetes
- ❑ Coronary, Pulmonary or Metabolic conditions.
- ❑ Symptomatic arrhythmias
- ❑ Recent embolism
- ❑ Hypertrophic cardiomyopathy
- ❑ Resting BP over 140/90
- ❑ Pulmonary hypertension
- ❑ Unstable angina
- ❑ Active thrombophlebitis
- ❑ Symptomatic congestive heart failure
- ❑ Symptomatic aortic stenosis

**Medical Screening Questions:**

1. Has the patient had an MI, CABG, angina, angioplasty or symptoms of coronary artery disease?

Yes_____ No_____ Date: _____ / _____ / _____

If yes, please explain limitations: _____

2. Has the patient had a history of Pulmonary, Metabolic, or Vascular Disease?

Yes_____ No_____ Date: _____ / _____ / _____

If yes, please explain limitations: _____

***If yes to either question 1 or 2, a treadmill stress test done within the last 12 months is required prior to enrollment. Please send a copy of recent treadmill results.***

_____Treadmill waived. I do not wish to perform a maximum treadmill test on this patient although he/she falls within the American College of Sports Medicine guidelines for testing prior to exercise.

Date of last treadmill: _____ / _____ / _____ (Please attach a copy)

Any abnormalities? _____

3. Has the patient recently undergone any surgery? Yes_____ No_____ Date: _____ / _____ / _____

If yes, please explain limitations: _____

4. Does the patient have any other medical condition that may limit exercise? Yes_____ No_____

If yes, please explain limitations: _____

**Exercise Recommendations:**

_____No Restrictions
_____Restricted from the following activities:
_____Treadmill _____ Weight training _____ Steam room
_____Stairmaster _____Gym aerobics _____ Swimming
_____Bike _____ Water aerobics _____Other: _____
_____Rowing machine _____ Recreational sports

Physician Signature: _____ Date: _____ / _____ / _____